REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

PATIENT AUTHORIZATION CONSENT

Patient name: Date of birth:

I,_____, the patient have read and understand the following documents that were given to me to review. I understand that these documents can be found on Reis Pediatrics website.

1. Patient-Provider Agreement
2. HIPPA Patient Acknowledgement
3. Patient Financial Responsibility
4. Medicare Lifetime Authorization
5. Insurance Authorization
6. Medical Treatment Authorization

Name of patient

Signature Date

As required by the Affordable Care Act, we have been asked to collect the following information for the federal government:.
Please circle one answer from each question:

1. Ethnicity: Hispanic/Latino Non Hispanic/Latino Refuse to Report

2. Race: American Indian or Native Alaskan Asian Black or African American
White Native Hawaiian or Other Pacific Islander
More than one race Refuse to Report

3. Preferred Language: English If other please specify_____